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RESEARCH ON PTSD AND OTHER POST-TRAUMATIC REACTIONS: EUROPEAN LITERATURE (Part II)

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This is the second of a two-part series by Drs. Weisæth and Eitinger on the European PTSD literature. Our previous issue focused on Norwegian publications, and this issue concludes with a review of publications from other European countries.

PTSD is a diagnosis that spans national and cultural boundaries, even though it is strictly defined as such only in the diagnostic manual of the American Psychiatric Association. Change is underway, however, to promote the systematic global use of the term. If the 1990 draft of the proposed ICD-10 (the International Classification of Diseases) is accepted, a diagnosis of post-traumatic stress disorder will be used internationally. In addition, the ICD-10 proposes a diagnosis of "acute stress reaction." This must have an immediate onset, defined as developing within one hour of exposure to the exceptional mental or physical stressor. Some of our own prospective studies starting in the immediate aftermath have found a high predictive validity of an acute diagnosis. This lends support to such a diagnostic proposal, which could also eliminate the problem that the DSM-III-R diagnosis of PTSD applies only after one month. In some other studies, for example, one on rape victims (this issue), the acute response was not predictive of PTSD; a combined formula of risk factors was needed for prediction. In addition, the ICD-10 proposes a diagnosis of "enduring personality change after catastrophic experiences" when the specific personality changes have been present for at least three years. The changes meeting the criteria will often have been preceded by a long-lasting post-traumatic stress disorder. There are extensive ongoing consultations between the ICD-10 and DSM-IV committees. Summing up, it will be an exciting challenge for the researcher in traumatic stress over the next few years to determine diagnostic categories that match clinical reality.

This article concludes our two-part review of the European literature on PTSD. Because of the vast amount of material available, we have by necessity been extremely selective in both reviews. We cannot do justice to all the recently published work reflecting the current intense interest in traumas connected with child abuse, wife battering, rape, AIDS, and violent crimes. Instead we have given priority to coverage of studies from different countries and languages, and important war-related studies of newer and older dates. We hope that our review contributes to an appreciation of the international, interdisciplinary nature of PTSD research.

*WISMIC, World Veterans Federation International Socio-Medical Information Center, was established in 1988 at the Division of Disaster Psychiatry, University of Oslo, which is also the central psychiatric unit of the Norwegian Armed Forces Medical Service. Norway was chosen because it had already nurtured a scientific tradition in research on the effects of trauma and stress caused by war on civilian populations and had combined this with active military psychiatry. Today, this research has been expanded to cover victims of present-day disasters and the various kinds of life-threatening individual traumas. The object of the Center is to collect, analyze, and distribute medical information on short-, medium-, and long-term post-traumatic stress disorders (PTSD) and other psychosocial medical problems related to war stress experiences and severe stress situations of similar character, including those concerning women and children.

The *WISMIC Newsletter* is published twice a year and sent to all member organizations of WVF and other bodies connected with the medical and social problems of war veterans and victims of disasters. Its object is to present in an informal way developments in current research and to draw attention to previous work often originally published in a European language other than English and in the form of a report or dissertation. Contents include reviews, original contributions, interviews, and editorial comment. Collective subscriptions are most welcome. Address: The Editor (Professor Lars Weisæth, MD, PhD), WISMIC, P.O. Box 39, 0320 Oslo 3, Norway.

SELECTED ABSTRACTS

FISCHER-HOMBERGER, E. (1975). **Die traumatische Neurose** [Traumatic neurosis]. Bern, Stuttgart, Vienna: H. Huber.

The author of this important book has set herself the difficult task of following the crooked, but extremely interesting, development of the concept of traumatic neurosis. Although the study more or less concerns the period up until 1930 and thus omits a crucial period in European history and German psychiatry as well, the book is a veritable mine of information. Perhaps most important are the frequent connections made between cultural, social, and political conditions and psychiatric theory and practice. Traumatic neurosis appears as an "epidemic" illness, where psychiatric opinions and theories reflect the spirit of the age. In a period of prosperity and societal improvement, it was both easy and natural to see the connection between injuries and later psychological effects. During wartime, the object was to recruit as many active fighting soldiers as possible, and attitudes underwent a fundamental change.

During World War I, for instance, "epidemics" of traumatic neuroses were thought to be caused by shell explosions that brought about brain concussion and thus a tremor in the whole body. In Great Britain the syndrome was called "shell shock" and was assessed as typical traumatically conditioned neurosis — a war neurosis, but one with a somatic anchorage. Increasingly, however, theorists such as Charcot came to the conclusion that the cause for post-traumatic neurosis was to be found in psychic conditions. In Germany, where many psychiatrists labeled all psychogenic illness "hysteria," this caused a great deal of confusion over nomenclature, as well as a negative attitude toward "war neurotics." Some psychiatrists refused to use the label, although they had no hesitation in recognizing the psychogenesis of the condition.

The German military psychiatrists' acceptance of the psychogenesis of war neurosis/war hysteria led to the supposition that the symptoms were dependent on the individual's will power. The therapy was therefore to treat this "weak will power" with "causal will therapy." The patient's "desire for health" had to be aroused and bolstered by physiological exercises. The treatment was so painful that many patients preferred front-line duty, and were thus considered "cured."

Psychoanalysis regarded war neurosis as a "flight into illness," evidence of a soldier's wish to shirk his duty. Hypnosis and auto-suggestion, as used by the military doctors, were regarded as methods of treatment borrowed from psychoanalysis, though the latter had long since discontinued both methods. The concept of the unconscious, a central element of psychoanalysis, was not even included in German military and school psychiatry.

After the war, the term "traumatic neurosis" was almost abolished in Germany, replaced by "compensation neurosis," which was considered a "non-illness," not deserving of a pension. Traumatic experiences were belittled, and emphasis was put on predisposition, constitution, "degenerative inclination," and the like. It was a time of economic decline and near-misery in Germany; and the rise of Nazism was disastrous for German psychiatry. Neurotics were regarded as parasites on the nation ("Volkskörper"), and from there it was a short path to considering psychiatric patients as possessing a life not worth living ("lebensunwertes Leben"). But this period, as mentioned above, is not treated by the author. Unfortunate as it is that this "modern history" ends without a consideration of post-World War II developments, the book provides a thorough review of the sociological attitudes that made them possible.

FRASER, R., LESLIE, I.M. & PHELPS, D. (1942/43). **Psychiatric effects of personal experiences during bombing**. *Proceedings of the Royal Society of Medicine*, 36, 119-123.

This 10-month follow-up study of a representative group of persons who had undergone severe personal danger during the London air raids found that of 35 persons who had been buried underneath debris for over an hour after the bombing without sustaining physical injuries, 66% had developed temporary or persistent neurotic symptoms. In 40%, the stress reactions resulted in absence from work for three weeks or longer.

Of 94 persons who were uninjured after the blast, 61 developed clear-cut neurotic symptoms (65%). A comparison was made between the 61 cases and the 33 non-cases. While the case group had suffered a slightly more severe exposure to the danger, nearly half of them had suffered a definite personal loss (home or a close friend), as compared to only 4% of the non-cases. In the case group, stable as well as vulnerable personalities were found, but the latter did not recover within weeks as did the former.

PONTEVA, M. (1977). **Psykiatriset sairaudet Suomen puolustusvoimissa v.v. 1941-1944** [Psychiatric diseases in the Finnish defenses during the war 1941-1944: An epidemiological and a follow-up study of Finnish soldiers treated in war and field hospitals during the war in the years 1941-1944]. *Sotilaslääkieteellinen Aikakauslehti*, 52, 31-208.

Between 1941 and 1944 15,700 Finnish soldiers were treated in war and field hospitals for psychiatric reasons. About two thirds of neuropsychiatric patients were psychiatric. The proportion of psychogenic reactions varied and correlated with the amount of war casualties. The estimated psychiatric incidence rate was on average 14.8 to 15.8 per 1,000 men per year. The incidence was highest at the beginning of the war when Finnish troops were attacking, and rose again when the Russians' great summer operation began in June 1944. The main type of psychiatric disorder was neurosis, except in 1941 when psychogenic reactions dominated. In 1941, 36.7% were diagnosed as reactive disorder (transient personality reactions to acute or special stress), 33.7% as neurosis, 13.3% as personality disorder, 10.1% as mental deficiency, and 6.1% as psychotic disorder. In 1942, 1943, and 1944, 15.8%, 9.7%, and 16.9%, respectively, were diagnosed as suffering from such reactive disorders. The 1971 follow-up was carried out with a sampling ratio 1:60 of patients whose treatment period in some hospitals had been finished. Pneumonia cases, sampling ratio 1:6, were chosen as a control group.

In both groups the mortality rates after the war were somewhat higher than expected. The former psychiatric patients had a significantly higher morbidity of cardiovascular diseases and death from that cause.

While the military ability classification changed during the war years for the majority of the psychiatric patients (27.7% were discharged or had their service postponed), they retained their ability for civil work rather long after the war. However, a rapid decline in work ability began about six years earlier among the patients than among the controls: In 1971 34.3% of the former and 19.9% of the latter were entirely work-disabled, and an additional 8.6% and 3.2% respectively were partially disabled. Cardiovascular diseases were the most frequent cause for disability in both groups, followed by mental diseases in the patient group. Diseases of the musculoskeletal system were also significantly more frequent.

At the follow-up, 90.1% of those diagnosed during the war as suffering from reactive disorder had not had any postwar psychiatric care, compared to 81.1% of the neurotic category, 55.3% of the personality disorders, 50% of the mentally deficient, and 39.1% of the psychotic disorders.

In a discriminant analysis the best prediction of a wartime psychiatric disorder (sensitivity of 57% and specificity of 98% when tested retrospectively among the controls) was made by the variables of earlier psychiatric hospital care, ability for service before the disorder, psychic symptoms before the war, behavior disturbances before the war, and psychiatric heredity.

DANISH STUDIES OF CONCENTRATION CAMP SURVIVORS

HELWEG-LARSEN, P. et al. (1949). **Sultsygdommen og dens følgetilstander hos koncentrationslejringsfanger** [Famine disease and its consequences for concentration camp inmates]. *Ugeskrift for læger*, 111, 1217-1240.

HELWEG-LARSEN, P. et al. (1952). **Famine disease in German concentration camps**. *Acta Psychiatrica et Neurologica Scandinavica* (Suppl. 83), Copenhagen.

HERMAN, K. & THYGESEN, P. (1954). **Le syndrome des camps de concentration 8 ans après la libération** [The concentration camp syndrome 8 years after the liberation]. In P. Thygesen, *La Deportation dans les Camps de Concentration Allemands et ses Sequelles* (pp. 56-72). Paris: F.I.R.

JACOBSEN, E. (1955). **Luftencephalogrammet ved KZ-syndromet** [Pneumo-encephalogram and the concentration camp syndrome]. *Ugeskrift for læger*, 117, 809-819.

In 1947, Danish medical doctors who had been in German concentration camps started a comprehensive examination of 5 groups of former prisoners: (1) 566 repatriated prisoners examined by detailed questionnaires supplemented by interviews; (2) 52 examined in detail by medical and psychiatric specialists, for whom there was a high degree of accordance between the two kinds of examination; (3) 710 police officers who had been in a very severe Nazi concentration camp, examined mainly about their "nervousness"; (4) 67 former inmates examined in 1949; and (5) ex-prisoners who had been arrested but not deported.

Almost 75% of all the investigated ex-prisoners stated that they had suffered from or still had "neurotic" symptoms after their repatriation. The authors conclude that the "repatriation neurosis" was influenced by several factors: individual predisposition, war factors other than the deportation, conditions of repatriation, and psychological and physical stress.

In 1954, Herman and Thygesen reported 120 exclusively concentration camp prisoners suffering from "concentration camp syndrome," characterized by "uniform asthenic and vegetative symptoms in close constellation with emotional disturbances as well as signs of intellectual deterioration, which together with a visible physical decline in many cases show an acceleration of the aging process." They assume the existence of a lesional disorder.

In 1954, Jacobsen reported 15 pneumo-encephalographies undertaken on ex-concentration camp inmates; these demonstrated a remarkably uniform aspect of this disorder. None of the 15 patients suffered from severe neurological impairment, but all of them had reported considerable loss of weight, possibly an etiological factor of the concentration camp syndrome. Thygesen and Kieler (in Helweg-Larsen et al., 1952) investigated the influ-

ence of famine disease on concentration camp inmates and found the following six symptoms: (1) curtailment and brutalization of emotional and moral outlook; (2) impairment of memory; (3) diminished powers of spontaneous reaction; (4) a tendency to irritability and emotional instability; (5) absence of libido; and (6) dullness, in some cases developing into apathy. They conclude that the manifestations of mental dullness together with instances of apathy at the "mussulman stage" constitute an entity indisputably governed by the state of undernourishment.

NIELSEN, H. (1983). **Disability and mortality during the period of 1946-79 among members of the Danish resistance movement who were deported to German concentration camps**. *Ugeskrift for læger*, 145, 345-355.

Case-history and health assessment in 1947 showed these 1354 (1323 men and 31 women) patients were not primarily predisposed to disease or social maladjustment. In 1979, 692 (51%) were considered to be disabled >50%; 50% of the disabled ranged in age from 50-59 years, 23% were younger, and 27% were older. A latency factor is apparent from the fact that 3/4 of them were assessed as disabled after 1965. The incidence of disability increased gradually and was, for the age group 45-64 years during 1973 - 1976, 5.6 times greater than in the general population. During the 1946-1979 period, 441 died, as compared to 396.9 deaths in the general population of the same age distribution, a statistically significant excess mortality of 1.11, greatest during the period 1946-1950.

Taking into consideration the basically good health of the persons investigated, and elimination of those with the poorest health in the concentration camps, the excess mortality must be presumed to be relatively greater than the difference from the general population indicates. These results confirm previously published follow-up results concerning Norwegian prisoners.

TRAUMA RESEARCH IN THE NETHERLANDS

VAN DER PLOEG, H.M. & KLEIJN, W.C. (1989). **Being held hostage in the Netherlands: a study of long-term effects**. *Journal of Traumatic Stress*, 2, 153-169.

BROM, D., KLEBER, R.J. & DEFARES, P.B. (1989). **Brief psychotherapy for post-traumatic stress disorders**. *Journal of Consulting and Clinical Psychology*, 57, 607-612.

DRAIJER, N. (1990). **Seksuele traumatisering in de jeugd** [Sexual traumatization in the young]. Thesis, Amsterdam 1990. See Draijer, N. **Hidden trauma, the role of sexual and physical abuse in the etiology of women's mental disorders**. In I. Foeken et al., *On Love and Violence* (pp. 133-155). Amsterdam: Moon Foundation.

FALGER, P.R.J., OP DEN VELDE, W., HOVENS, J.E., SCHOUTEN, E.G.W., DE GROEN, J.H.M. & VAN DUIJN, H. (In press). **Current post-traumatic stress disorder, "vital exhaustion," and cardiovascular morbidity in male Dutch Resistance veterans of World War II**. *Psychotherapy and Psychosomatics*.

OP DEN VELDE, W., HOVENS, J.E., FALGER, P.R.J., DE GROEN, J.H.M., VAN DUIJN, H., LASSCHUIT, L.J. & SCHOUTEN, E.G.W. (In press). **PTSD in Dutch Resistance veterans from World War II**. In J.P. Wilson & B. Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes*. Chapter 18. New York: Plenum Press.

DE GROEN, J.H.M., OP DEN VELDE, W., VAN DUIJN, H., FALGER, P.R.J., HOVENS, J.E. & FLOS, M.F.R. (1990). **Post-traumatic nightmares and timing of REM sleep.** *Journal of Interdisciplinary Cycle Research*, 21, 192-193.

In the immediate postwar period, Dutch professionals considered the psychic problems of survivors as temporary. The few but important concentration camp studies attracted minor attention; gradually the focus shifted to non-war-related trauma. In the 1970s the Netherlands was confronted with 8 large-scale hijackings and siege incidents. Van der Ploeg and Kleijn directed follow-up studies on those who had been held hostage. Brom et al. compared various treatment strategies for civilian trauma victims. Draijer studied a national random sample of women with respect to experiences of sexual abuse.

From 1980 onwards, there has also been a growing interest in the fate and condition of victims of war. In 1982, the Dutch foundation ICODO (National Institute for the Victims of War) was founded. It provides legislative information and advice, supports individuals in finding medical and psychosocial assistance, and houses a library containing extensive documentation of war events and their psychosocial consequences.

In 1985, a multidisciplinary study on the current mental and physical health status, and postwar adjustment, of former members of the Dutch Resistance (1940-1945) was initiated. All subjects had been exposed to prolonged periods of war stress. The prevalence of current PTSD in the "very high war stress" group (N=147) was 54% and in the "high war stress" group (N=830) it was 21%. Lifetime prevalence of PTSD was substantially higher. Several developmental courses were found: (1) acute PTSD, becoming chronic; (2) delayed-onset PTSD, 5 to 40 years postwar; (3) a mixed condition of manifest PTSD immediately after the war, followed by symptom-free intervals of 15 to 30 years. Veterans not meeting DSM-III-R criteria for current PTSD frequently reported insomnia and intensification of distress after exposure to events resembling their war experiences. Actual duration of Resistance participation, and subsequent imprisonment, showed a positive correlation with PTSD. Resistance veterans reported significantly more physical complaints than a control group. Veterans currently diagnosed as having PTSD were significantly more depressed, more anxious, more angry, experienced less mental well-being, and suffered from more severe insomnia.

The overall impression from the life-history interviews concludes that severe traumatization and subsequent PTSD do not preclude good or even excellent social and professional functioning for considerable periods of time. However, most of the veterans retired early and were granted a disability pension at 50 to 55 years, and PTSD symptoms often continued and sometimes worsened after retirement. The divorce rate greatly exceeded that in the comparable Dutch population.

Furthermore, in a subsample of 30 veterans, two continuous 24-hour ambulatory sleep-wake polygraphy recordings, including EEG, ECG, actogram, body temperature, and sleep stage scoring, were performed. Twenty-two suffered from PTSD; eight were PTSD-free and served as controls. Night sleep in subjects with current PTSD was characterized by less total sleep time, diminished sleep efficiency, decreased REM-latency, and a decrease of stage III/IV sleep. Often, an internal dissociation of REM and non-REM sleep was observed. A decrease of stage III/IV sleep and of REM-latency is also found in major depression. Post-hoc analysis of the depression scores suggests that depression indeed plays a role. Furthermore, periodic leg movements and sleep-apneic periods frequently occurred in veterans with current PTSD. Several subjects had nightmares during

polygraphy, which could arise out of any stage of sleep, and often caused disruption of sleep. The data suggest that nightmares could be triggered by sleep-apneic episodes.

Finally, in an open, outpatient pilot study, 24 Resistance veterans were treated with fluvoxamine (Fevarin). After 7 to 12 weeks of treatment, a decrease of insomnia, trait anxiety, and vital exhaustion was observed in 12 of the 17 veterans who completed treatment.

KEILSON, H. (1979). **Sequentielle Traumatisierung bei Kindern** [Sequential traumatization of children]. Ferdinand Enke, Stuttgart.

KIELSON, H. (1980). **Sequential traumatization of children.** *Danish Medical Bulletin*, 27, 235-237.

This follow-up study on Jewish war orphans in the Netherlands found that there were no statistically significant differences between children who were in hiding places and children who survived the concentration camps. The author stresses, however, that the degree of trauma entailed in the deportation of parents with their children and the subsequent experiences at the camps cannot be statistically compared with the effect of the hidden children's memories of an uncertain farewell and fantasies about the fate of their parents.

GERMAN STUDIES: EXTREME LEBENSVERHÄLTNISSE ALS RISIKOFAKTOREN

[Extreme life circumstances as risk factors]

Band 1: SCHENCK, E.G. (1975). **Katamnestische Erhebungen über ehemalige Kriegsgefangene — Saarland-Studie** [Catamnestic examinations of former prisoners of war. The Saar region study]. Stuttgart: Gentner.

Band 2: BÖGER, A., SCHENCK, E.G., THÜRAUF, J., VALENTIN, H. & WELTLE, D. (1975). **Epidemiologische Studie über die Todesursachen ehemaliger Kriegsgefangener — Nürnberg-Studie I** [An epidemiological study of causes of death in former prisoners of war. The Nuremberg-study I].

Band 3: THÜRAUF, J., SCHENCK, E.G., VALENTIN, H. & WELTLE, D. (1975). **Studie über die Sterblichkeit ehemaliger Kriegsgefangener in Nürnberg — "Nürnberg-Studie" II** [A study of the mortality of former prisoners of war in Nuremberg. The Nuremberg study II].

Band 4: SCHENCK, E.G. (1976). **Ergebnisse einer Befragung und Untersuchung ehemaliger Kriegsgefangener — Stuttgart-Studie** [Results of a questionnaire investigation of former prisoners of war. The Stuttgart study].

Band 5: SCHENCK, E.G., SCHEIDT, G. & GOETZ, E. (1984). **Sterbealter und Todesursachen ehemaliger Wehrmachtsangehöriger mit und ohne Kriegsgefangenschaft sowie rassistisch und politisch Verfolgter — München-Studie** [Age and causes of death in former members of the Wehrmacht with and without imprisonment as well as of persons persecuted because of their race and politics. The Munich study].

Band 6: SCHENCK, E.G. (1979) **Die ärztliche Beurteilung von Gesundheitsschäden bei ehemaligen Kriegsgefangenen** [The medical evaluation of health impairment in former prisoners of war].

Band 7: HÖPKER, W.-W. (1982). **Spätfolgen extremer Lebensverhältnisse** [Long-term outcomes of extreme life circumstances].

Band 8: PAUL, H.A. (1986). **Einflüsse extremer Belastungen auf die psychischen und psychosozialen Verhältnisse ehemaliger Kriegsgefangener** [The influence of extreme stress on the psychological and psychosocial life circumstances of former prisoners of war].

These books describe several important investigations from the postwar period on different groups of Germans who had been POWs in countries occupied or at war with Germany in the years 1939-1940. Investigators divided subjects into those who had been imprisoned in "eastern" countries (the Soviet Union, Yugoslavia, Poland, and Czechoslovakia) and "western" countries (Africa, the U.S., Great Britain, France, and Italy).

It is quite impossible to give even an indicative report on all the variables measured. As expected, it was found that the "eastern" prisoners had a significantly longer and more severe imprisonment with substantially greater incidence of disease than the equivalent "western" prisoners. Even in 1956-1957 they complained significantly more frequently of various somatic and vegetative-dystonic conditions and of feeling "unwell."

Unfortunately, in postwar Germany it was very difficult to investigate the total population of ex-prisoners or a representative sample of it. The authors estimate that as late as 1973 about 10% of the population alive in West Germany then had been exposed to extreme living conditions for several war years, whether as POWs, civilian internees, or concentration camp prisoners. It is therefore natural that only a few selected groups could be investigated thoroughly. Also, the psychiatric and psychosomatic investigations are quantitatively rather modest and exclusively based upon test protocols, with few basic clinical studies. Nonetheless, the books offer a wealth of important information for any person concerned with extreme life stress. Some volumes have English and/or French summaries.

FRENCH STUDIES

CROCQ, M.A. ET AL. (In press) **Severity of the prisoner of war experience and post-traumatic stress disorder**. *European Journal of Psychiatry*.

This paper reports on a population of 817 men from Alsace-Lorraine, forcibly drafted into the German armed forces during WWII to serve on the Eastern front and subsequently detained as POWs in the USSR under extreme conditions. They were studied by questionnaire. The authors were interested in the relationship between duration and severity of POW captivity and the subsequent presence of PTSD as defined in the DSM-III. This population is homogeneous in terms of ethnic, cultural, and geographical background; all experienced traumatic events of the same nature during combat and captivity. The authors found that the presumptive diagnosis of PTSD was significantly associated with long internment and with higher scores on the index measuring severity of POW experience.

They are, however, very critical of the DSM-III diagnostic criteria of PTSD symptoms. They point out that unpleasant recall may be "normal" and is hard to differentiate from intrusive PTSD symptoms in the less severe cases. This may contribute to an exaggeration of the prevalence of PTSD as evaluated by self-report questionnaires. Symptoms which are related to social withdrawal, avoidance of social groups, feeling of being different

from others (estrangement), and a hostile or distrustful attitude toward the world may be more significant discriminators of psychopathology and handicap after four decades. In chronic forms of PTSD, it appears meaningful to separate these protracted symptoms from those which are related to reexperiencing the trauma and avoiding stimuli, thus being more episodic by nature. In addition, symptoms of increased arousal, such as difficulty in falling asleep, have little diagnostic specificity in this sample of elderly men.

CROCQ, L. & CROCQ, M.A. (1987). **Trauma and personality in the causation of war neuroses**. In G. Belenky (Ed.), *Contemporary Studies in Combat Psychiatry* (pp. 103-116). New York: Greenwood Press.

The authors review the problem of interaction between the premorbid personality and the traumatic war experiences in the pathogenesis of war neuroses. They refer to the high proportion of "neurotic predisposition" (up to 80% of cases) found in war neuroses during WWII. Statistics from the Algerian War (1958-1962) show only 14.5% (185 cases) of war neuroses, compared with 51% (647) psychoses and 14.5% (184) mental retardations. This would possibly indicate an inadequate selection procedure. The authors are somewhat critical of the alleged high frequency (78%) of premorbid neuroses and try to prove their point of view by several case histories. They stress that the vulnerability caused by the past personality "is not an unescapable fate" and that every traumatic neurosis has a trauma at its origin.

SCANDINAVIAN STUDIES OF CIVILIAN TRAUMA

RASMUSSEN, O.V. (1990). **Medical aspects of torture**. *Danish Medical Bulletin*, 37 (Suppl. 1), 1-88.

The present study has four specific goals:

1. Based on the medical records from the examinations of 200 persons who alleged they had been tortured, to describe different types of torture and resulting symptoms and lesions, to evaluate their consequences with regard to diagnostic significance and the person's health, and to relate the results to today's accumulated knowledge on the subject.
2. To evaluate the influence of exile on health complaints in torture victims.
3. To describe the kind and frequency of medical involvement in torture victims.
4. To describe the existing relationship between the medical profession and torture, and to make proposals as to how the medical profession can be used in the prevention of torture.

The examinations were carried out in Denmark and during missions to other countries. Nineteen nationalities were represented, and the alleged torture had taken place in 18 different countries. In general, the examined persons were young, healthy, well educated, and employed. The examination took place three days to twelve years (median two years) after the torture, which mainly took place during the early period of captivity. There was considerable overlap between reported physical and mental types of torture. Forty-one of the 200 examined torture victims reported that medical personnel were involved in their torture.

The author concludes by recommending that doctors who are found guilty of torture should not be allowed to practice medicine in any country of the world and that both governmental and non-governmental international medical bodies should be encouraged to incorporate the prevention of torture into their programs.

DAHL, S. (1991). **Rape — a health hazard.** Manuscript submitted for publication.

DAHL, S. (1989). **Acute response to rape — a PTSD variant.** *Acta Psychiatrica Scandinavica*, 80, (Suppl. 355) 56-62.

In these studies, 55 rape victims were found to suffer more acute guilt, shame, and suicidal ideation than victims of civilian accidents or industrial disaster. The response to rape changed most significantly the first three months, but one group of victims remained unchanged or got worse in the course of the first year, after which 49% met the criteria for the DSM-III-R diagnosis of PTSD, sexual disorders, depressive disorders, or social phobia. In all, 30% met the criteria for a PTSD diagnosis and another 29% had moderate post-traumatic stress reactions/symptoms.

Factors predicting psychiatric outcome were for the whole diagnostic group completed rape (penetration) and low social support. A condition for development of PTSD was a violence/threat factor. At one year, PTSD was associated with previous psychiatric impairment and blame from close friends and relatives. Blame turned out to be an important additional factor for those who had no psychiatric functional impairment in the past. Depressive symptoms were associated with more than one offender, intense shame reaction in the acute phase, sexual or violent traumatization in the past, and a perceived negative reaction from police. Sexual disorders after rape were more frequent in those who were satisfied with life prior to the event and who had an intense acute depressive reaction and ideas of having been damaged.

SWEDISH STUDIES IN DISASTER PSYCHIATRY

LUNDIN, T. (1982). **Sorg och sorgreaktioner. En studie av vuxnas reaktioner efter plötsliga och oväntade dödsfall.** [Mourning and grief. A study on reactions to sudden and unexpected bereavement]. Thesis in Swedish with a summary in English, Uppsala University, 255 pp.

LUNDIN, T. (1984a). **Morbidity following sudden and unexpected bereavement.** *British Journal of Psychiatry*, 144, 84-88.

LUNDIN, T. (1984b). **Long-term outcomes of bereavement.** *British Journal of Psychiatry*, 145, 424-428.

LUNDIN, T. (1987). **The stress of unexpected bereavement.** *Stress Medicine*, 3, 109-114.

KALLENBERG, K. & LUNDIN, T. (1987). **The effects of sudden and unexpected bereavement on outcome, belief systems and concept of life.** Appendix 2 in Kallenberg, *Livsaskådnings kris* (pp. 145-159). Lund: Doxa.

LUNDIN, T. (1990). **Bereavement in late adolescence — after a major fire disaster.** *Bereavement Care*, 9, 7-8.

These studies focus on the stress of unexpected and traumatic bereavement. In one set of studies (Lundin 1982, 1987), 18 were followed in a prospective interview investigation for two years: 8 relatives developed a problematic grief with a great proportion of anxiety. Of these, widows were concerned about what they could have done to prevent the death of their husbands, while the parents were wondering if they had been good parents and if they had done enough for their children. Eleven of the parents had lost a child in late adolescence. The suddenness of the deaths seemed to make the problems of guilt worse. Only five of the interviewees had seen the dead body. Among those who did not see the dead body some showed a prolonged initial denial.

The researchers found that sudden bereavement may result in different pathological conditions, including pathological grief, anxiety states, major depression, self-destructive behavior, and reactive psychosis. The concept of PTSD (post-traumatic stress disorder) should be used only concerning psychological problems related to survival.

In another study, 130 first-degree relatives were examined eight years after bereavement (Lundin 1984b). Relatives of suddenly and unexpectedly deceased persons had a deeper level of mourning and significantly more guilt feelings; they also reported more numbness, they missed the deceased person more, and had a greater need to cry.

OTTO, U., BLIDING, A., FRIES, H. & LUNDIN, T. (1986) **Katastrof- och Försvarpsykiatri.** [Disaster and Military Psychiatry]. Lund: Student Litteratur.

This is a comprehensive Swedish textbook covering practically all traumatic stress issues of relevance for countries with total defense planning (as opposed to purely professional military defense).

ADDITIONAL CITATIONS

Evidence of torture: Studies by the Amnesty International Danish Medical Group (1977). Copenhagen: Amnesty International.

Examination by a Danish medical study group accumulated information about torture in general, and related early and late sequelae to these methods. Sixty-seven Chilean and Greek torture victims were studied. The victims had suffered many different kinds of physical violence and mental stress. The sequelae of torture are complex, and there are clear indications that specific sequelae can be related to specific torture techniques.

ELAND, J., VAN DER VELDE, P.G., KLEBER, R.J. & STEINMETZ, C.H.D. (1990). **Tweede generatie Joodse Nederlanders** [The Dutch Jewish Second Generation].

Deventer: Van Loghum Slaterus.

Studied a sample of thirty Jewish persons born after 1945. Interviews and clinical reports clearly showed that mental problems are over-represented in the target group, and that their need for professional mental help is also more urgent than that of the controls.

AARTS, P.G.H., ELAND, J., KLEBER, R.J. & WEERTS, J.M.P. (1991). **De joodse naoorlogse generatie: Onuitwisbare sporen?** [The Jewish postwar generation: Ineffaceable traces?]. Houten: Bohn Stafleu Van Loghum.

Describes the problems and treatment of the so-called "second generation." Aimed at nonspecialized social workers and psychotherapists.

SZWARC, H. (1985). **The premature aging of former KZ-prisoners.** *Zeitschrift für Alternsforschung*, 40, 209-212.

Studied the most frequent chronic diseases of former concentration camp prisoners at the present time. Circulatory diseases, bone and joint diseases, and neuroses and mental diseases dominate. Multimorbidity leads to premature aging; three/ four chronic diseases were found in one person. Most mental diseases and neuroses were found in the youngest group. The premature aging in most cases is caused by environmental factors. Strong and distressful emotional experiences, shocks, and psychological traumas have a destructive effect on metabolism and can lead to acceleration of the life rhythm.

PAUL, H.R. & HERBERG, H.J. (Ed.) (1967). **Psychische Spätschäden nach politischer Verfolgung** [Psychic sequelae of political persecution]. Basel: Karger.

HERBERG, H.J. (Ed.) (1971). **Beurteilung von Gesundheitsschäden nach Gefangenschaft und Verfolgung** [Views on health impairment after imprisonment and persecution]. Herford: Nicolaische Verlagsbuchhandlung.

HERBERG, H.J. (Ed.) (1971). **Spätschäden nach Extrembelastungen** [Sequelae of extreme stress]. Herford: Nicolaische Verlagsbuchhandlung.

Presented at three different international meetings concerning the late sequelae of concentration camps, these papers represent both Eastern European and West German scientists, and give a many-sided picture of the problems involved in studies of this kind.

BEGEMANN, F.A. (1991). **Het onvertelbare verhaal.** [The unsayable]. Amsterdam: Swets & Zeitlinger.

Focuses on some practical and moral questions confronting helpers working with resistance veterans and with Jewish or Indo-European clients, and with their offspring. In-depth interviews were held with leading Dutch psychotherapists, and with professionals of other agencies working for war victims. Psychodynamic, family-oriented, and group therapeutic approaches in psychotherapy for children of war victims are described. The role of historical and cultural factors in the therapeutic process is also explored.

Die Auschwitz-Hefte [The Auschwitz papers]. *Bd I & II* (1987) Weinheim, Basel: Beltz Verlag.

Written by Polish former inmates, these papers have been translated into German and describe their lives, medical experiences, sufferings, inner defeats, struggles, and deliverance. Many of the publications are based on questionnaires and give broad information about Auschwitz. The limitation of the books is the fact that prisoners of other nationalities are barely mentioned.

BASTIAANS, J. (1957). **Psychosomatische gevolgen van onderdrukking en verzet** [Psychosomatic sequelae of persecution and resistance]. Amsterdam: Noord-Hollandsche Uitgevers Maats.

Describes the Dutch findings in concentration camp survivors and resistance fighters that opened the way for further research in the field.

O'BRIEN, L.S. & HUGHES, S.J. (1991). **Symptoms of post-traumatic stress disorder in Falklands veterans five years after the conflict.** *British Journal of Psychiatry*, 159, 135-141.

Studied and compared a group of Falklands war veterans still serving in the British Army with a group of matched controls. Fifty percent of the veterans reported some symptoms of PTSD, while 22% reported symptoms indicative of the complete PTSD syndrome. Presence of the symptoms was associated with intensity of combat experience and the retrospective report of emotional difficulties in the initial period on return from the war. The differences between this group and groups of Vietnam veterans are considered, as is the low rate of recognized acute psychiatric disturbance at the time of the conflict. The significance of the symptoms reported is also discussed.

TORRIE, A. (1944). **Psychosomatic casualties in the Middle East.** *Lancet*, 139-143.

Outlines 2500 psychosomatic casualties in the Middle East during 1942, and gives a more detailed description of 1000 cases of anxiety neurosis and hysteria. Of these cases a quarter had had prewar neurosis; 89.9% were returned to duty (58.6% to full duty, 31.3% to base duty) and 5.4% were invalided. Average stay in hospital was 18.1 days. Cases were selected for treatment by grouping them into three classes. Recovery was facilitated by the nurse with psychological understanding, the speedy removal of untreatable cases, the staging of a suitable war environment coupled with rapid reconditioning, and the full-time employment of all patients who are up. Suggests that hospitals in peacetime might adapt a considerable number of neurotic patients to employment by similar methods.

WEISÆTH, L. & SUND, A. (1982) **Psychiatric problems in UNIFIL and the UN-soldier's stress syndrome.** *Revue Internationale des Services de Santé*, 55, 109-116.

Reports on psychiatric problems in the ten-nation UN infantry battalions on a peacekeeping mission in South Lebanon 1978-1980. The most important problem for the UN soldier was conflict arising from the suppression of aggressive impulses. In PTSD cases, this conflict contributed to fear of losing control over one's aggression rather than fear of external threats.

PLOEGER, A. (1977). **A 10-year follow up of miners trapped for 2 weeks under threatening circumstances.** *Stress and Anxiety*, 4, 23-28.

Studying the Lengede mine disaster in West Germany, Ploeger found that 9 of the 10 miners who consented to the ten-year follow-up inquiry showed an irritable-explosive change of personality. Six suffered from specific trauma-linked phobias and nine from intrusive recollections. Bothersome memories and dreams had subsided somewhat during recent years, but still nine had nightmares about the disaster. Depressions were not observed, and the personality changes resembled post-cerebral trauma sequelae and could not be ascribed entirely to the psychological stress exposure. Some of the post-traumatic psychiatric symptoms represented an exacerbation of pre-catastrophic traits: paranoid querulent development in two miners, obsession syndromes in two, schizoid contact disturbances in two, and bouts of hyperventilation in one.

BOUTHILLON, P., CROCQ, L., JULIEN, H. & NOTO, R. (1990). **Stress psychique des victimes des attentats terroristes et ses suites lointaines** [Psychological stress and its long-term effects in victims of terrorist attacks]. *Urgences*, 9, 102-105.

In 1986 there were 10 terrorist attacks in Paris and 247 persons were admitted to hospitals as a consequence of these attacks. After 3 years only 142 of these could be located. They received questionnaires, but only 43 of these could be used. Thirty-four (79%) had symptoms of a traumatic neurosis and/or psychosomatic symptoms. The authors stress the importance of immediate psychological treatment in order to prevent long-term effects in the victims of terrorist attacks.

CROCQ, L. (1986). **The stress of war** [Le stress de guerre]. *Neuro-Psychiatrique*, 1, 149-158.

Reviews, historically and clinically, the most important normal and pathological emotional reactions to combat situations. The author discusses the experiences and different reactions of groups who are not directly and actively engaged in combat, their "social stress," and the danger of panic reactions in both military and civil populations. Furthermore, he briefly presents some of the etiological theories and the most important preventive and therapeutic activities necessary.

PILOTS UPDATE

We are pleased to report that there are now 2,470 citations in the PILOTS database. By the end of October that number should reach 3,000, with another 500 records added each quarter. While the database is by no means complete, it now contains enough material so that a search on almost any topic represented in the PTSD literature should retrieve useful material.

At present almost all citations in PILOTS are to English-language publications. We have been collecting material in other languages, and are beginning to plan for adding foreign-language citations to the database. The first languages to be added will be Spanish, French, and German, in that order; though if we are successful in negotiating licenses with other database producers for the use of their English-language abstracts, we will be able to add some material in other languages as well.

The material that we are adding to PILOTS falls into two categories: current and retrospective literature. We are identifying new publications on PTSD and related forms of traumatic stress by examining *Current Contents* on a weekly basis, by searching several established databases (including MEDLINE and PSYCINFO) for articles on PTSD, and by encouraging workers in the field to send us copies of their papers upon publication. Retrospective publications are identified through computer searching and by using printed bibliographies. We are still working on the extensive PTSD material from MEDLINE, PSYCINFO, and the Arnold PTSD bibliography (Veterans Administration, 1987); when we have completed identifying, obtaining, indexing, and entering all of these papers, we will begin with material from other sources. We use other bibliographic sources only as a locating device; we do not copy indexing information or proprietary abstracts from other databases into PILOTS. Thus it takes longer for records to be added, but all PILOTS records are indexed using the same vocabulary and following the same rules, facilitating searching by users. There is an old adage in bibliography: "that which saves the compiler's time costs the user his." We are trying to ensure that the time saved by our way of doing things is the user's.

One way to save the user's time is to provide a good set of instructions. A draft version of the PILOTS User's

Guide is now being circulated among a representative sample of potential searchers. This publication includes a statement of the scope and inclusion policies of the PILOTS database, a detailed guide to searching PILOTS using BRS / SEARCH or ProCite software, and the complete PILOTS Thesaurus. These will make it possible to design and execute searches that will retrieve the papers best suited to any PTSD-related information need. We are negotiating with a publisher for distribution of the completed User's Guide, and also for distribution of PILOTS on floppy disk so that frequent users can search the database without maintaining an account with an online search service. We are also exploring several other avenues for making PILOTS available to users. It is too early to discuss these now, but when there is progress to report it will be reported here.

It has been two years since we began planning this project. While we have made a substantial amount of progress, there is still much to be done. We would very much like to hear from PILOTS users, both those who have been successful in finding the literature they sought and those whose experiences with PILOTS have been frustrating or unproductive. PILOTS is still new enough and small enough to be responsive to user feedback. Our goal is to meet the informational needs of the PTSD community. Your comments will help us to meet that goal. Please address all comments to:

Dr. Fred Lerner, Information Scientist
National Center for PTSD (116D)
VA Medical Center
White River Junction, Vermont 05009
(802) 296-5132

To search PILOTS on BRS:

1. log onto BRS
2. at the "FILE" prompt type **CHID**
3. as your first search statement, type **pt.an.** (be sure to include that final period)
4. execute all subsequent search statements within that first set.